

Department of Health and Human Services Public Health Service		Leave blank — for PHS use only.	
Small Business Innovation Research Program <b>Phase II Grant Application</b> <i>Follow instructions carefully.</i>		Type	Activity
		Review Group	Number
		Council Board ( <i>Month, year</i> )	Formerly
		Date Received	
1a. TITLE OF APPLICATION ( <i>Do not exceed 56 typewriter spaces</i> )		1b. Phase I Grant No.	
2. PRINCIPAL INVESTIGATOR <input type="checkbox"/> New Investigator			
2a. NAME ( <i>Last, first, middle</i> )		2b. DEGREE(S)	2c. SOCIAL SECURITY NO.
2d. POSITION TITLE		2e. MAILING ADDRESS ( <i>Street, city, state, zip code</i> )	
2f. TELEPHONE AND FAX ( <i>Area code, number, and extension</i> ) TEL: FAX:		BITNET/INTERNET Address:	
3. HUMAN SUBJECTS <input type="checkbox"/> NO <input type="checkbox"/> YES		3a. If "yes," Exemption no. or <input type="checkbox"/> IRB approval date <input type="checkbox"/> Full IRB or Expedited Review	
		3b. Assurance of compliance no.	
		4. VERTEBRATE ANIMALS <input type="checkbox"/> NO <input type="checkbox"/> YES	
		4a. If "Yes," IACUC approval date <input type="checkbox"/>	
		4b. Animal welfare assurance no. <input type="checkbox"/>	
5. DATES OF ENTIRE PROPOSED PHASE II PERIOD <i>From:</i> <i>Through:</i>		6. COSTS REQUESTED FOR FIRST 12-MONTH BUDGET PERIOD 6a. Direct Costs \$ 6b. Total Costs \$	
		7. COSTS REQUESTED FOR ENTIRE PROPOSED PHASE II PERIOD 7a. Direct Costs \$ 7b. Total Costs \$	
8. PERFORMANCE SITES ( <i>Organizations and addresses</i> )		9. APPLICANT ORGANIZATION ( <i>Name and address of applicant small business concern</i> )	
		10. ENTITY IDENTIFICATION NUMBER Congressional District	
11. INVENTIONS AND PATENTS <input type="checkbox"/> Previously reported OR <input type="checkbox"/> NO <input type="checkbox"/> YES If "Yes," <input type="checkbox"/> Not previously reported		12. SMALL BUSINESS CERTIFICATION <input type="checkbox"/> Small Business Concern <input type="checkbox"/> Women-owned <input type="checkbox"/> Socially and Economically Disadvantaged	
13. NOTICE OF PROPRIETARY INFORMATION: The information identified by asterisks(*) on pages _____ of this application constitutes trade secrets or information that is commercial or financial and confidential or privileged. It is furnished to the Government in confidence with the understanding that such information shall be used or disclosed only for evaluation of this application, provided that, if a grant is awarded as a result of or in connection with the submission of this application, the Government shall have the right to use or disclose the information herein to the extent provided by law. This restriction does not limit the Government's right to use the information if it is obtained without restriction from another source.		15. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name: Title: Address:  Telephone: FAX: BITNET/INTERNET Address:	
14. DISCLOSURE PERMISSION STATEMENT: If this application does not result in an award, is the Government permitted to disclose the title only of your proposed project, and the name, address, and telephone number of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information or possible investment? <input type="checkbox"/> YES <input type="checkbox"/> NO			
16. PRINCIPAL INVESTIGATOR ASSURANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.		SIGNATURE OF PERSON NAMED IN 2a (In ink. "Per" signature not acceptable.)	
17. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Service terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.		DATE	
		SIGNATURE OF PERSON NAMED IN 15 (In ink. "Per" signature not acceptable.)	
		DATE	
PHS 6246-2 (Rev. 1/95) Face Page			

Principal Investigator (*Last, first, middle*): \_\_\_\_\_

## Abstract of Research Plan

NAME, ADDRESS, AND TELEPHONE NUMBER OF APPLICANT ORGANIZATION

YEAR FIRM FOUNDED

NO. OF EMPLOYEES (*include all affiliates*)

TITLE OF APPLICATION

KEY PERSONNEL ENGAGED ON PROJECT

NAME	ORGANIZATION	ROLE ON PROJECT
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**ABSTRACT OF RESEARCH PLAN:** State the application's broad, long-term objectives and specific aims, making reference to the health-relatedness of the project. Describe concisely the research design and methods for achieving these goals and discuss the potential of the research for technological innovation. Avoid summaries of past accomplishments and the use of the first person. This abstract is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. ***Therefore, do not include proprietary or confidential information.*** DO NOT EXCEED 200 WORDS.

Provide key words (8 maximum) to identify the research or technology.

Provide a brief summary of the potential commercial applications of the research.

**Small Business Innovation Research Program  
Phase II Grant Application  
Table of Contents**

Number pages consecutively at the bottom throughout the application. Do not use suffixes such as 5a, 5b. Type the name of the Principal Investigator at the top of each printed page and each continuation page.

	<i>Page Numbers</i>
Face Page, Abstract, Table of Contents .....	1–3
Detailed Budget for First 12-Month Budget Period .....	4
Budget for Entire Proposed Phase II Period .....	5
Budgets Pertaining to Contractual Arrangements .....	_____
Biographical Sketch—Principal Investigator ( <i>Not to exceed two pages</i> ) .....	_____
Other Biographical Sketches ( <i>Not to exceed two pages for each</i> ) .....	_____
Other Support .....	_____
Resources .....	_____

**Research Plan**

Introduction to Revised Application ( <i>Not to exceed one page</i> ) .....	_____
1. Specific Aims .....	_____
2. Significance .....	_____
3. Phase I Final Report ( <i>Recommended not to exceed ten pages</i> ) .....	_____
4. Experimental Design and Methods .....	_____
5. Human Subjects .....	_____
6. Vertebrate Animals .....	_____
7. Consultants .....	_____
8. Consortium Arrangements .....	_____
9. Literature Cited .....	_____
Checklist .....	_____

*\*Type density and type size of the entire application must conform to limits provided in application instructions under "Type Size."*

**Appendix** (*Three sets. No page numbering necessary for Appendix.*)

Number of publications and manuscripts accepted for publication (*Not to exceed ten*): \_\_\_\_\_

Other items (*list*): \_\_\_\_\_

## Detailed Budget for First 12-Month Budget Period— Direct Costs Only

FROM \_\_\_\_\_

TO \_\_\_\_\_

PERSONNEL <i>(Applicant organization only)</i>					DOLLAR AMOUNT REQUESTED <i>(omit cents)</i>		
NAME	Role on Project	Type Appt. (months)	% Effort on Project	Institutional Base Salary	Salary Requested	Fringe Benefits	TOTALS
<b>SUBTOTALS</b> →							

CONSULTANT COSTS

EQUIPMENT *(Itemize)*SUPPLIES *(Itemize by category)*

TRAVEL

PATIENT CARE COSTS

Inpatient

Outpatient

ALTERATIONS AND RENOVATIONS *(Itemize by category)*

CONTRACTUAL COSTS

OTHER EXPENSES *(Itemize by category)*
**TOTAL DIRECT COSTS FOR FIRST 12-MONTH BUDGET PERIOD** *(Also enter on Face Page, Item 6a)* →

\$

FIXED FEE REQUESTED

\$

## Budget for Entire Proposed Phase II Period— Direct Costs and Fixed Fee

BUDGET CATEGORY TOTALS		FIRST BUDGET PERIOD (from Page 4)	SECOND BUDGET PERIOD	THIRD BUDGET PERIOD (if necessary)
PERSONNEL <i>(Salary and fringe benefits)</i> <i>(Applicant organization only)</i>				
CONSULTANT COSTS				
EQUIPMENT				
SUPPLIES				
TRAVEL				
PATIENT CARE COSTS	INPATIENT			
	OUTPATIENT			
ALTERATIONS AND RENOVATIONS				
CONTRACTUAL COSTS				
OTHER EXPENSES				
<b>Total Direct Costs</b>				

**Total Direct Costs for  
Entire Proposed Phase II Period** *(Also enter on Face Page, Item 7a)* —————→

\$

JUSTIFICATION: Describe the specific functions of the personnel and consultants. For ALL years, justify any unusual items such as major equipment, foreign travel, alterations and renovations, patient care costs, and contractual costs. Identify with an asterisk any significant increases or decreases from the first budget period and explain and justify all categories marked with an asterisk. Justify any request that exceeds the overall SBIR Phase II limitations of cost (\$750,000) and period of support (two years). Use continuation page(s) if necessary.

BUDGET CATEGORY TOTALS		FIRST BUDGET PERIOD (from Page 4)	SECOND BUDGET PERIOD	THIRD BUDGET PERIOD (if necessary)
<b>Fixed Fee Requested</b>				

**Total Fixed Fee Requested for  
Entire Proposed Phase II Period** *(Add to "total direct costs for entire proposed phase II period" above and "indirect costs for entire proposed phase II period" from Checklist [form page 9] and enter new total on Face Page, Item 7b.)* —————→

\$

## Biographical Sketch

Provide the following information for the key personnel listed on Page 2, beginning with the Principal Investigator. Photocopy this page or follow this format for each person.

NAME	POSITION TITLE		
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education. Include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR CONFERRED	FIELD OF STUDY

RESEARCH AND/OR PROFESSIONAL EXPERIENCE: Concluding with present position, list in chronological order previous employment, experience, and honors. Include present membership on any Federal Government public advisory committee. List, in chronological order, the titles, authors, and complete references to those publications most pertinent to this application. **DO NOT EXCEED TWO PAGES.**

## Other Support

(Use continuation pages if necessary. Include the Principal Investigator's name at the top and number consecutively.)

**FOLLOW INSTRUCTIONS CAREFULLY.** Incomplete, inaccurate, or ambiguous information could lead to significant delays in the review and/or possible funding of this application. OTHER SUPPORT is defined as *all financial resources*, whether Federal, non-Federal, commercial, or institutional, *available in direct support of an individual's research endeavors*, including, but not limited to, research grants, cooperative agreements, contracts, and/or institutional awards. **DO NOT INCLUDE TRAINING AWARDS, PRIZES, OR GIFTS.**

Information on active and pending OTHER SUPPORT is required for **each** of the key personnel listed on Page 2, **excluding** consultants. Indicate "None" for individuals with no active or pending support. **DO NOT SUBMIT** a separate page for each person listed for whom "None" is indicated. List OTHER SUPPORT in two separate groups: (1) *all* currently active support, and (2) *all* applications and proposals pending review *or* funding (*do not include this application*). In a separate group, *list any other active or pending support to the applicant organization (small business concern) for work related to **this** project*. For all groups, specifically identify projects under the Small Business Innovation Research (SBIR) program and the Small Business Technology Transfer (STTR) program. If the support is provided under a subcontract arrangement or is part of a multi-project award, identify the principal investigator and provide the data below for both the parent and the subproject.

For each item, provide: (a) source of support, identifying number, title, and inclusive dates of the project as approved (for *active* awards) or proposed (for *pending* support); (b) brief statement of overall objectives of the project, subproject, or subcontract; (c) *annual* direct costs as approved or proposed; and (d) percentage of effort on the project. After listing all OTHER SUPPORT, summarize for each individual any potential overlap with active or pending projects and *this* application in terms of the science, budget, or an individual's committed effort. (See instructions for definitions of the three types of overlap.) Any necessary resolution of overlap due to this application being funded will occur in conjunction with the applicant organization and the Public Health Service awarding component staff at the time of award.

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## Resources

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**FACILITIES:** Specify the facilities to be used for the conduct of the proposed research. Indicate the facilities at the applicant small business concern and any other performance site listed on the FACE PAGE where the facilities are located and describe their capacities, pertinent capabilities, relative proximity, and extent of availability to the project. Under "Other," identify support services such as secretarial, machine shop, electronics shop, and the extent to which they will be available to the project. Use continuation page(s) if necessary.

Laboratory:

Clinical:

Animal:

Computer:

Office:

Other:

**MAJOR EQUIPMENT:** List the most important equipment items already available for this project, noting the location and pertinent capabilities of each.



**Checklist***This is the required last page of the application.***TYPE OF APPLICATION** (Check appropriate box(es).)

- ☐ NEW application. (This application is being submitted to the Public Health Service for the first time.)
- ☐ REVISION of previously-submitted application number \_\_\_\_\_  
(This application replaces a prior unfunded version of a new application.)
- ☐ CHANGE of Principal Investigator (if applicable)  
Name of former Principal Investigator \_\_\_\_\_

**1. ASSURANCES/CERTIFICATIONS**

The assurances/certifications set forth below are made and verified by the signature of the OFFICIAL SIGNING FOR APPLICANT ORGANIZATION (small business concern) on the FACE PAGE of the application. Descriptions of individual assurances/certifications are found in application instructions under "Checklist." If unable to certify compliance with any item, provide an explanation and place it after this page.

• Human Subjects; • Vertebrate Animals; • Debarment and Suspension; • Drug-Free Workplace; • Lobbying; • Delinquent Federal Debt; • Research Misconduct; • Civil Rights (Form HHS 690); • Handicapped Individuals (Form HHS 690); • Age Discrimination (Form HHS 690); • Financial Conflict of Interest.

**2. PROGRAM INCOME** (See discussion in application instructions under "Checklist.")

All applications must indicate (Yes or No) whether program income is anticipated during the period for which grant support is requested.

- ☐ No ☐ Yes (If "Yes," use the format below to reflect the amount and source(s) of anticipated program income.)

Budget Period	Anticipated Amount	Source(s)

**3. INDIRECT COSTS** (See discussion in application instructions under "Checklist.")

Insert the rate, if known. If the applicant organization does not have a currently negotiated rate with the Department of Health and Human Services (DHHS) or another Federal agency, it must estimate the amount of indirect costs allocable (applicable) to the proposed Phase II project. That amount should be inserted in the space provided below. The

applicant organization should also be prepared to furnish financial documentation to support the estimated amount, if requested by the Public Health Service. An applicant organization may elect to waive indirect costs if it so desires.

- ☐ DHHS agreement, dated: \_\_\_\_\_ ☐ No indirect costs requested.
- ☐ No DHHS agreement, but rate established with \_\_\_\_\_, dated: \_\_\_\_\_
- ☐ Rate negotiation pending with the National Institutes of Health.

**CALCULATION\***

(The entire grant application, including the Checklist, will be reproduced and provided to peer reviewers as CONFIDENTIAL information. Supplying the following information on indirect costs is OPTIONAL.)

**a. First 12-month budget period:**

Amount of base \$ \_\_\_\_\_ x Rate applied \_\_\_\_\_ % = indirect costs (1) \$ \_\_\_\_\_

**b. Entire proposed Phase II period:**

Amount of base \$ \_\_\_\_\_ x Rate applied \_\_\_\_\_ % = indirect costs (2) \$ \_\_\_\_\_

(1) Add to "total direct costs" and "fixed fee requested" from form Page 4 and enter new total on Face Page, Item 6b.

(2) Add to "total direct costs" and "fixed fee requested" from form Page 5 and enter new total on Face Page, Item 7b.

\*Check appropriate box(es):

- ☐ Salary and wages base ☐ Modified total direct costs base ☐ Other base (Explain on separate page.)
- ☐ Off-site, other special rate, or more than one rate involved (Explain on separate page.)

**4. SMOKE-FREE WORKPLACE**

Does your organization currently provide a smoke-free workplace and/or promote the non-use of tobacco products or have plans to do so?

- ☐ Yes ☐ No (The response to this question has no impact on the review or funding of this application.)